

MONTANA BOARD OF VETERINARY MEDICINE

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<http://www.discoveringmontana.com/dli/vet>

AFFIX RECENT
PHOTO HERE
PASSPORT SIZE

Application for Licensure as Embryo Transfer Technician

1. FULL NAME _____
Last First Middle

2. OTHER NAME(S) KNOWN BY _____

3. BUSINESS NAME: _____

4. BUSINESS ADDRESS _____
Street or PO Box # City State Zip Country

5. HOME ADDRESS _____
Street or PO Box # City State Zip Country

PREFERRED MAILING ADDRESS: ☐ Business ☐ Home E-MAIL ADDRESS _____

6. TELEPHONE (____) _____ (____) _____ (____) _____
Business Home Fax

7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____

8. DATE OF BIRTH _____ PLACE OF BIRTH _____
City/State ☐ MALE ☐ FEMALE

9. LICENSE NAME _____
(State your name as it should appear on the license if granted.)

10. Academic Degrees Received: (Include certificates equivalent to degrees. List latest degree first)

Degree	Date Received	Institution	Major	Minor(s)

11. Professional Experience as an Embryo Transfer Technician. List all experience of professional consequence including unpaid as well as paid, concurrent as well as consecutive, starting at date of application and working back to graduation.

Date:	From	To
Organization/Address:		
Exact Title:		
Hours per week:	Paid: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Name, title and present address of immediate supervisor:		

Description of work:

Date: From	To
Organization/Address:	
Exact Title:	
Hours per week:	Paid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, title and present address of immediate supervisor:	
Description of work:	

Date: From	To
Organization/Address:	
Exact Title:	
Hours per week:	Paid: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name, title and present address of immediate supervisor:	
Description of work:	

Please answer the following questions. If you answer yes, give specific details (names of organizations, dates, reasons, and outcome) on a Supplementary Sheet.

- | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----|----|
| 12. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. | Yes | No |
| 13. Do you have criminal charges pending or have you ever pled guilty or been convicted of a crime (including a plea of no contest or deferred prosecution) relating to, or committed during the course of your professional practice, involving violence, use or sale of drugs, fraud, deceit, or theft, whether or not an appeal is pending? You may omit: (1) traffic violations for which you paid a fine of \$100.00 or less and (2) charges or convictions prior to your 16 th birthday. If yes, attach a detailed explanation. | Yes | No |
| 14. Has any legal or disciplinary action been filed against you which relates to the propriety or your fitness to practice as an embryo transfer technician? If yes, attach explanation. | Yes | No |
| 15. Have you ever been charged with fraud, formally or informally, in any civil proceeding? If yes, attach a detailed explanation. | Yes | No |
| 16. Have you been found using any prescription drugs, alcoholic beverages, or illegal chemical substances with in the last three years to an extent that such use has impaired your ability to perform the work of an embryo transfer technician with safety to the public? | Yes | No |
| 17. Have you been treated for the use or misuse of any prescription drug, alcoholic beverage or illegal chemical substance within the last three years? | Yes | No |
| 18. Have you been hospitalized or a patient in a mental or other institution of confinement or have you been treated for a mental or behavioral condition within the last three years? | Yes | No |
| 19. Has a complaint ever been made against you alleging unethical behavior or unprofessional conduct? | Yes | No |

20. Have you ever been denied the right to sit a licensing examination in any state? If yes, give details. Yes No

21. Have you ever sat for the ET exam in Montana or any other state? If yes, give state, date, and results. Yes No

22. List any and all states and Canadian provinces in which you have ever been certified.

State/Canadian Provinces	License Number	Date Issued	Is the license Current		Specialty
			Yes	No	
			Yes	No	
			Yes	No	

23. Do you have any physical impairment(s) requiring special accommodations in taking the examination? Please include a statement of your needs with this application. Yes No

24. Have you ever had a license (certificate) denied, revoked, or suspended? If yes, give details. Yes No

25. Has your license (certificate) ever been forfeited or surrendered? If yes, give details. Yes No

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice, by anyone who might possess such information, to the Montana Department of Labor and Industry, Healthcare Licensing Bureau.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

Legal Signature of Applicant _____

Dated _____

Subscribed and sworn to before me this _____ day of _____, _____ at

City/State _____.

Signature of Notary Public _____

SEAL

Notary Public Printed Name _____

For the State of _____

My commission expires _____, _____.